AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		IPLE CONSTRUCTION	(X3) DATE : COMPL	
Poc	井1	445491	B. WIN				С
NAME OF F	ROVIDER OR SUPPLIER			err	REET ADDRESS, CITY, STATE, ZIP CO		26/2012
MCKEN	DREE VILLAGE INC			4	347 LEBANON ROAD IERMITAGE, TN 37076	DDE .	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) GOMPLETIC DATE
F 000	INITIAL COMMENT	s	FO	00	Allegation of Substantial Con	npliance	
F 226 SS=D	investigation of TN(483.13 regulations f 483.13(c) DEVELOR ABUSE/NEGLECT, The facility must dev policies and procedumistreatment, negler	ETC POLICIES /elop and implement written	F 2:	26	McKendree Village Healthcar (herein after sometimes "facil continues to be in substantial with 42 CFR Part 482.13, Refor Long Term Care Facilities McKendree Village Healthcar or will have substantially corralleged deficiencies and achie substantial compliance by the 2012 specified herein.	ity") has and compliance quirements it. The Center has rected the eved	
	by: Based on review of review of a facility in- review and interview	T is not met as evidenced the facility's abuse policy, vestigation, medical record the facility failed to	į.		This Plan of Correction const McKendree Village Healthcar allegation of substantial comp that the alleged deficiencies c been or will be substantially c or before 10 OCT 2012	re Center's diance such ited have	
	physician of alleged a ensure Social Servic reaction to alleged se (#1) of five interview	abuse policy to notify the sexual abuse and failed to e monitored the resident's exual abuse for one Resident able sampled residents.			The statements made on this properties are not an admission not constitute an agreement walleged deficiencies herein. To remain in substantial compliant CFR Part 482.13, Requirement	on to and do ith the o continue to nce with 42	
	Facility Management "Policy Interpretation	's "Reporting Abuse to " policy revealed under and Implementation 9.			Term Care Facilities, McKend Healthcare Center has taken of the actions set forth in this pla correction.	lree Village г will take	
1	or confirmed, the inci reported to facility ma time lapse since the i	resident abuse is suspected dent must be immediately inagement regardless of the noident occurred. 10. Upon			F226 483.13(c) DEVELOP/IN ABUSE/NEGLECT, ETC PO	LICIES	
i l e	receiving reports of p icensed nurse or phy examine the resident.	hysical or sexual abuse, a sician shall immediately			The facility has and will conti implement the facility abuse p		
ORATORY (DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNA	TURE		TITLE A	Fil in	X6) DATE
wing the da	te of survey whether or no	asterisk (*) denotes a deficiency which stion to the patients. (See instructions.) of a plan of correction is provided. For are made available to the facility. If de	except re	יר חנ	ursing nomes, the findings stated ab	ove¦ are disclosab	le 90 days

OCT 1 1 2012

If continuation sheet Page 1 of 8

PRINTED: 09/28/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				FORM	. 03/20/2012 APPROVED . 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			URVEY ETED	
		445491	B. Wit	NG_			C 26/2012
	ROVIDER OR SUPPLIER OREE VILLAGE INC			4	REET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 226	examination must of findings on approve information concern Director of Nursing representative of the monitor the resident statements regarding involvement in the investment of Nursing his/her findings." Medical record reviadmitted to the facilidiagnoses of History Convulsions, Hemip Depressive Disorder (MDS) dated March Resident scored 15 on the Brief Interviet The MDS also reveatedling down, depreday, but showed not review of the facility a Care Plan meeting July 17, 2012 at 10:10 Interim Director of Nate of the Resident's moth phone present for the Care Plan meeting the facility staff that she touched by two differences.	The person performing the locument the examination of forms13. Upon receiving ning a report of abuse, the Services will request that a le Social Services Department it's reactions to and lighthe incident and his/her investigation. 14. Unless the nerwise, the social service live the Administrator and Services a written report of lew revealed Resident #1 was ity on September 9, 2011 with ly of Brain Tumor, paresis, Esophageal Reflux, or and Acute Sinusitis. Terly Minimum Data Set learny Minimum Data Set learny le	F	226	facility has and will continue to physician / medical staff in accowith the facility abuse policy. The has and will continue to assure the residents receive necessary social monitoring and support in according the facility abuse policy. On or before 10 OCT 2012 the Insurance of the facility abuse policy. On or before 10 OCT 2012 the Insurance of the facility abuse policy. On or before 10 OCT 2012 the Insurance of the standards in the service will be conducted by the standards regally and the standards re	rdance The facility hat all services dance with Director of and Social rvice. The the vill regulation statement plan of facility's arding dical staff lated to abuse physician facility's rding monitoring residents tion of umentation ce and support	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/28/201 APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING	(X3) DATE S	
		445491	B. WING	ş	09/2	C 26/2012
	PROVIDER OR SUPPLIER DREE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076		.0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	One instance was be Resident was able to was by a female (Cleould not identify by facility staff the incidenceurred about six wand the incident with four weeks prior to allegation, the Residescription of the all interview conducted DON. Further review of the revealed there was a facility's investigation was notified or documentation of the alleged Review of all Medicathe Resident made as on July 17, 2012, revide documentation of the documentation of the documentation of the the physician or Note the incident. Review of Social Ser revealed no documentation about the alleged about the Resident had bee Service between July	by a male (CNT #2) that the o identify and one instance NT #1) that the Resident mame. The Resident told the lent with CNT #2 had weeks prior to July 17, 2012 in CNT #1 had occurred about July 17, 2012. In each dent gave a detailed leged sexual abuse during an by the Administrator and by the Administrator and efacility's investigation in the Resident's physician mentation that Social if the Resident following the abuse. all Progress Notes dated after allegations of sexual abuse we alleged abuse or tesident had been examined lurse Practitioner in relation	F 22	Based on a thorough and complinivestigation of Resident #1's a that included multiple interview resident, staff and other resident observations and discussion with resident's physician, there was not to substantiate the resident's alleabuse/inappropriate touching. Resident #1 continues to receive care and services according to he care and physicians orders. The receiving psycho-social services licensed professional. The care plan for Resident #1 has reviewed to ensure the intervent continue to meet the resident's reaccordance with the regulations policy and notification of the physocial service staff is made so the necessary examinations and evaluate provided and documented in medical record. The Administrator or designee wany allegations of abuse that has made in last 30 days to ensure the necessary physician/ medical stantifications have occurred and necessary social services/, medical services/	allegations s with the ss, h the no evidence egation of e necessary her plan of resident is s from a as been ions needs. tigated in and facility ysician and hat any aluations the will review we been hat aff that any cal/ and or	

Review of the Social Service Progress Notes dated August 20, 2012 documented, "SW (Social

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445491	B. WIN	G		1	C 86/2012
	ROVIDER OR SUPPLIER			43	EET ADDRESS, CITY, STATE, ZIP CODE 47 LEBANON ROAD ERMITAGE, TN 37076		.0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	(Resident #1's) dec familyDiscussed I available and she re talk it over with spot Review of the Social dated September 5 signed Consent to s (Nurse Practitioner) depression." Reside time by Psych servicalmost seven weeks alleged abuse.	ol for with) patient today about line in mood per nursing and Psych services that is equested to think about it and	F2	26	that the notifications and services been documented. Beginning 8 OCT 2012 The Adm or designee will monitor for conticompliance through chart audits. (Attachment F226). The audits will completed weekly for one month monthly for up to one quarter. The Administrator or designee will rep QA/QI committee who will determ frequency of further monitoring.	inistrator nued (See Il be and e	
	on September 11, 2 conference room, the the interviews, I talk not talk to (Resident getting involved."	with the Social Worker (SW) 012 at 2:23 p.m. in the ie SW stated "I helped with ed to other residents, but I did t #1). I didn't feel the need for with the Resident on	1		Completion 10 OCT 2012:		
	September 11, 2012 room, the Resident meeting, I think in A about counseling. It it. After a few weeks came out to see me don't remember exa [named Social Works.]	2 at 3:05 p.m. in the resident's stated "The last care plan ugust they (facility) asked me told them I would be open to a, someone from psyche, it was a few days ago. I ctly when. I don't think ter] talked to me about it (the e). I talked to [named		-			
	18, 2012 at 1:20 p.m revealed the SW wa	with the SW on September i. in the conference room, s unfamiliar with the role of ng an abuse investigation per					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/28/2012 1 APPROVED	
T I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION	(X3) DATE S COMPLI	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
· <u> </u>		445491	B. WIN	NG	1	C 26/2012	
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PRRECTION N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE	
F 250 SS=D	the facility policy. During an interview September 18, 2012 conference, the Adr [named interim DOI physician, but she whave a new DON yet (Resident #1's) doct it's documented." The facility did not puthe Resident's physicial Service monito alleged sexual abt 483.15(g)(1) PROVIRELATED SOCIAL The facility must proservices to attain or practicable physical, well-being of each results of the properties of the properties of the provided facility failed to ensure options for emotional for one resident (#1) five interviewable said The findings included Review of the facility.	with the Administrator on 2 at 1:50 p.m. in the ministrator stated, "I think NJ documented calling the vas just filling in, we didn't et. I think I mentioned it to for, I'm not sure. I don't think to rovide documentation that ician was notified or that tored the Resident's reaction use. SION OF MEDICALLY SERVICE vide medically-related social maintain the highest mental, and psychosocial esident. T is not met as evidenced the Social Worker Job review, and interview the re Social Services provided I support in a timely manner who alleged sexual abuse of mpled residents.	F 2	 Review of to deficience Review of to deficience Review of to correction Review of to description service staff Social Services ponsibility assessment of emotions 	inue to ensure ces are ely manner of abuse. Social Service The inthe ind will the regulation the statement cy the plan of the job for social f. ice ities regarding and provision al support and for residents is an of abuse ice and ion of the		

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 09/28/2012
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	· ·	445491	B. WIN	1G_		Į.	С
NAME OF	PROVIDER OR SUPPLIER					09.	/26/2012
MCKEN	DREE VILLAGE INC			4:	EET ADDRESS, CITY, STATE, ZIP CODE 347 LEBANON ROAD ERMITAGE, TN 37076		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	N D BE	(X5) COMPLETION DATE
	related emotional ar residents are met' Facilitates the social of residents and the make better or more of residents and farm. Medical record revies and admitted to the facility diagnoses of Hill Convulsions, Hemips Depressive Disorder. Review of the Quarter (MDS) dated March Resident scored 15 for Mental Status (Bluthe Resident's mood depressed or hopeles showed no signs of depressed for the facility staff that she had been depressed for the Care Plan meeting the facility staff that she had been depressed for the facility staff that she had	or ensuring that the medically and social needs of the under "Duties of the Job - I and psychological well being ir families Ameliorates (to tolerable) emotional distress villes." We revealed Resident #1 was facility on September 9, 2011 story of Brain Tumor, aresis, Esophageal Reflux, and Acute Sinusitis. Parly Minimum Data Set 11, 2011 revealed the of 15 on the Brief Interview MS). The MDS also revealed was feeling down, as nearly every day, but lelirium. Is investigation documented was held at the facility on DAM with the Administrator, are meeting. At the end of the eresident informed the ad been inappropriately ent Certified Nursing two different instances. In male (CNT #2) that the identify and one instance 1. The Resident told the large to the resident told the large. The Resident told the large the resident told the	F 2		related to an abuse allegation. Review of the far abuse policy Based on a thorough and complete investigation of Resident #1's alleg that included multiple interviews we resident, staff and other residents, observations and discussion with the resident's physician, there was no eto substantiate the resident's allegar abuse/inappropriate touching. Resident #1 continues to receive necessary care and services account to her plan of care and physician orders. The resident is receiving psycho-social services from a lipprofessional. The care plan for Resident #1 has be reviewed to ensure the intervention continue to meet the resident's need. Any allegation of abuse is investifuaccordance with the regulations a facility policy and notification of physician and social service staff made so that any necessary examinant evaluations are provided.	gations with the second of	
- 11	acility staff the incider	ame. The Resident told the nt with CNT #2 had eks prior to July 17, 2012			:		,

DEPARTI CENTER	MENT OF HEALTH S FOR MEDICARE	AND HUMAN SERVICES -			FORM): 09/28/2012 APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	1	X2) MULTIPLE CONSTRUCTION A. BUILDING		0. 0938-0391 SURVEY ETED
· · · · · · · · · · · · · · · · · · ·		445491	B. WING	S	09/2	C 26/2012
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI	ECTION	(X5)
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
f a control of the co	our weeks prior to allegation, the Residescription of the allescription of the severaled there was acility's investigation terviewed the Resident alleged abuse. Review of the Social evealed no docume bout the alleged abuse are Resident had be service between Jul 012 (over one monbuse). Review of the Social ated August 20, 20 Vorker) met (symbol Resident #1's) declimityDiscussed Parailable and she really it over with spourated September 5, 20 gned Consent to separactitioner) for (sympolescription). The Reme by Psych service	In CNT #1 had occurred about July 17, 2012. In each July 18, 2012 in each July 18, 2012 and August 20, th since the report of alleged Services Progress Notes Progress No	F 25	The Administrator or designee vany allegations of abuse that has made in the last 30 days to ensure necessary physician/ medical st notifications have occurred and necessary social services/, medic psychosocial follow up has occurred that the notifications and services been documented. Beginning 8 OCT 2012 the Administrator or designee will for continued compliance through (See Attachment F250). The be completed weekly for one monthly for up to one quarter. Administrator or designee will the QA/QI committee who will determine the frequency of fur monitoring. Completion 10 OCT 2012:	re been re that aff that any cal/ and or curred. And es have I monitor ough audits. audits will month and The I report to	

		: & MEDICAID SERVICES			OMB NO). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
<u> </u>		445491	B. WING_		09/	C 26/2012	
	PROVIDER OR SUPPLIER DREE VILLAGE INC		4	REET ADDRESS, CITY, STATE, ZIP 1347 LEBANON ROAD HERMITAGE, TN 37076			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 250	During an interview on September 11, 2 conference room, it the interviews, I talk not talk to (Residen getting involved." During an interview September 11, 201 room, the Resident meeting, I think in A about counseling. I it. After a few weeks came out to see me don't remember exalinamed Social World	with the Social Worker (SW) 2012 at 2:23 PM in the he SW stated "I helped with ked to other residents, but I did it #1). I didn't feel the need for with the Resident on 2 at 3:05 PM in the resident's stated "The last care plan august they (facility) asked me told them I would be open to s, someone from psyche e, it was a few days ago. I actly when, I don't think ker] talked to me about it (the se). I talked to [named]	F 250				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/28/2012

FORM APPROVED